

1 ENVIRONMENTAL AND PUBLIC PROTECTION CABINET

2 DEPARTMENT OF PUBLIC PROTECTION

3 OFFICE OF INSURANCE

4 DIVISION OF HEALTH INSURANCE POLICY AND MANAGED CARE

5 (Emergency Amendment)

6 806 KAR 17:280E. Registration, utilization review, and internal appeal.

7 RELATES TO: KRS 304.17-412, 304.17A-605, 304.17A-609, 304.17A-613, 304.18-
8 045, 304.32-147, 2004 Ky. Acts ch. 59, sec 5, 304.38-225

9 STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-609, 304.17A-613

10 NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the
11 commissioner to promulgate reasonable administrative regulations necessary for or as an aid to
12 the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010.

13 KRS 304.17A-609 requires the department to promulgate emergency administrative regulations
14 regarding utilization review and internal appeal. KRS 304.17A-613 requires the department to
15 promulgate emergency administrative regulations to develop a process for the registration of
16 insurers or private review agents. Executive Order-064, filed December 23, 2003, created the
17 Environmental and Public Protection Cabinet. Executive Order 2004-031, filed January 6, 2004,
18 abolished the Department of Insurance and transferred all its “duties, functions, responsibilities,
19 records, equipment, staff and support budgets” to the Office of Insurance. This administrative

1 regulation establishes requirements for the registration of insurers or private review agents, and
2 the utilization review process, including internal appeal of decisions.

3 Section 1. Definitions.

4 (1) "Adverse determination" is defined in KRS 304.17A-600(1).

5 (2) "Board" means one (1) of the following governing bodies:

6 (a) The American Board of Medical Specialties;

7 (b) The American Osteopathic Association; or

8 (c) The American Board of Podiatric Surgery.

9 (3) "Coverage denial" is defined in KRS 304.17A-617(1).

10 (4) "Department" means the Department of Insurance.

11 (5) "Enrollee" is defined in KRS 304.17C-010(2).

12 (6) "Insurer" is defined in KRS 304.17A-600(8).

13 (7) "Limited health service benefit plan" is defined in KRS 304.17C-010(5).

14 (8) "Nationally-recognized accreditation organization" is defined in KRS 304.17A-
15 600(10).

16 (9) "Notice of coverage denial" means a letter, a notice, or an explanation of benefits
17 statement advising of a coverage denial as defined by KRS 304.17A-617(1).

18 (10) "Policies and procedures" means the documentation which outlines and governs
19 the steps and standards used to carry out functions of the utilization review program, the release
20 of which is governed by KRS 304.17A-613(6).

21 (11) "Private review agent" is defined in KRS 304.17A-600(11).

22 (12) "Qualified personnel" is defined in KRS 304.17A-600(14).

23 (13) "Registration" is defined in KRS 304.17A-600(15).

1 (14) "Utilization review" is defined in KRS 304.17A-600.

2 (15) "Utilization review plan" is defined in KRS 304.17A-600.

3 Section 2. Registration Required.

4 (1) The department shall issue or renew a registration to an applicant that has met all
5 requirements of KRS 304.17A-600 through 304.17A-619 and 304.17A-623, if applicable, and
6 Sections 2 through 11 of this administrative regulation.

7 (2) An applicant seeking issuance or renewal of registration shall:

8 (a) Submit an application for issuance or renewal of registration to the
9 department as required by Section 4 of this administrative regulation; and

10 (b) Pay an application fee as required by Section 3 of this administrative
11 regulation.

12 (3) An application for issuance or renewal of registration shall be accompanied by the
13 required documentation listed in Section 4 of this administrative regulation.

14 (4) An application for renewal of registration shall be submitted to the department at
15 least ninety (90) days prior to expiration of the registration.

16 Section 3. Fees.

17 (1) An application for issuance or renewal of registration shall be accompanied by a
18 fee of \$1,000.

19 (2) A submission of changes to utilization review policies or procedures to the
20 department shall be accompanied by a fee of fifty (50) dollars.

21 Section 4. Application Process.

(1) An applicant shall complete and submit to the department a utilization review registration application, HIPMC-UR-1 (10/02), which shall comply with the requirements established by KRS 304.17A-600 through 304.17A-619, as applicable, including:

(a) A utilization review plan that includes the items listed in KRS 304.17A-609(1);

(b) The identification of utilization review criteria, including criteria for review of inpatient and outpatient services;

(c) Types and qualifications of personnel performing utilization review in compliance with KRS 304.17A-607(1)(a), including[:

~~1. Names]~~ names, addresses, and telephone numbers of the medical director and contact persons for questions regarding the filing of the application; ~~and~~

~~2. Qualifications of personnel employed directly or under contract by various job category;]~~

(d) A toll-free telephone number to contact the insurer, limited health service benefit plan, or private review agent, as required by KRS 304.17A-607(1)(e) and 304.17A-609(3);

(e) A copy of the policies and procedures required by KRS 304.17A-609(4) regarding reasonable accessibility during normal business hours in this state;

(f) A copy of the policies and procedures to ensure availability to conduct utilization review including the response time to return telephone calls if an answering machine is used, in accordance with KRS 304.17A-607(1)(f);

(g) A copy of the policies and procedures by which:

1 1. A limited health service benefit plan shall provide a notice of
2 review decision which complies with KRS 304.17A-607(1)(j) and, if applicable, 304.17A-
3 607(1)(h), concerning a denial, limitation, reduction, or termination of health care benefits and
4 which includes:

- 5 a. Date of the review decision; and
- 6 b. Instructions for filing an internal appeal; or

7 2. An insurer or private review agent provides a notice of review
8 decision, which complies with KRS 304.17A-607(1)(j) and, if applicable, KRS 304.17A-
9 607(1)(h) and 806 KAR 17:230, concerning a denial, limitation, reduction, or termination of
10 health care benefits and which includes:

- 11 a. Date of the review decision;
- 12 b. Instructions for filing an internal appeal, including
13 information concerning:

- 14 (i) the availability of an expedited internal appeal; and
- 15 (ii) for an adverse determination, a covered person's
16 right to request a review of the appeal by a board eligible or certified physician; and

- 17 c. Information relating to the availability of:
 - 18 (i) A review of a coverage denial by the department
19 following completion of the internal appeal process; and
 - 20 (ii) A review of an adverse determination by an
21 independent review entity following completion of the internal appeal process, in accordance
22 with KRS 304.17A-623;

1 (h) If only a part of the utilization review process, rather than the entire
2 utilization review process, is delegated, a description of the:

- 3 1. Delegated function;
- 4 2. Entity to whom the function was delegated by name, address, and
5 telephone number; and
- 6 3. Monitoring mechanism used by the insurer or private review agent
7 to assure compliance with paragraph (g) of this subsection;

8 (i) A sample copy of any electronic or written notice of review decision, as
9 applicable, in compliance with paragraph (g) of this subsection;

10 (j) A copy of the policies and procedures by which a covered person,
11 authorized person, or provider can appeal an adverse determination or coverage denial in
12 accordance with KRS 304.17A-617, including:

- 13 1. The method by which an appeal may be initiated, including:
 - 14 a. An oral request followed up by an abbreviated written
15 request, or a written request for an expedited internal appeal;
 - 16 b. A written request for a nonexpedited internal appeal; and
 - 17 c. The completion of any specific forms, including a medical
18 records release consent form;
- 19 2. Time frames for conducting review of an initial decision and for
20 issuing an internal appeal decision;
- 21 3. Procedures for expedited and nonexpedited appeals;
- 22 4. Qualifications of the person conducting internal appeal of the
23 initial decision; and

1 5. Information to be included in the internal appeal determination in
2 accordance with KRS 304.17A-617(2)(e), including:

3 a. The title, and if applicable, the license number, state of
4 licensure, and certification of specialty of the person making the internal appeal determination;

5 b. ~~[A description of the basis for the appeal;~~
6 ~~e.]~~The decision in clear terms and sufficient detail to explain the
7 decision; and

8 ~~c.[d.]~~ Instructions for requesting:

9 (i) An external review of an adverse determination
10 upheld by the internal appeal determination, including the availability of an expedited external
11 review; or

12 (ii) Departmental review of a coverage denial upheld by
13 the internal appeal determination; and

14 6. A sample copy of the internal appeal determination to be sent in
15 compliance with paragraph (j)5 of this subsection;

16 (k) A copy of the policies and procedures to:

17 1. Protect the confidentiality of medical information in accordance
18 with KRS 304.17A-609(5);

19 2. Comply with requirements of KRS 304.17A-615 relating to
20 payment if the insurer or private review agent fails to:

21 a. Provide a timely utilization review decision; or

b. Be accessible, as determined by verifiable documentation of a provider's attempts to contact, including verification by electronic transmission records or telephone company logs;

3. Comply with requirements of KRS 304.17A-619 regarding the submission of new clinical information prior to the initiation of the external review process;

4. Ensure consistent application of review criteria for inpatient and outpatient services in the rendering of review decisions; and

5. Comply with requirements of KRS 304.17A-607(1)(k) regarding the review and comment on protocols by participating physicians and other providers, as applicable;

(l) If applicable, a~~A~~ copy of the written materials that provide covered persons, enrollees of limited health service benefit plans, and providers with the following information at the time of enrollment and thereafter upon request, and the mechanism for disseminating the written material:

1. Their rights, responsibilities and liabilities in accessing covered services subject to utilization review, including the documentation requirements of KRS 304.17A-615 and identify:

a. When utilization review is required;

b. Who may request utilization review; and

c. When the insurer, limited health service benefit plan, or private review agent shall be contacted;

2. Telephone numbers and hours of operation of the insurer, limited health service benefit plan, or private review agent and how to contact the insurer, limited health

1 service benefit plan, or private review agent for a review determination after normal business
2 hours;

3 3. Time frames for utilization review decisions in accordance with
4 KRS 304.17A-607(1)(h)~~[, including an additional:~~

5 a. ~~Twenty four (24) hours for an insurer, limited health~~
6 ~~service benefit plan, or private review agent to obtain needed information to provide a~~
7 ~~preadmission utilization review decision; and~~

8 b. ~~The time for an insurer, limited health service benefit plan,~~
9 ~~or private review agent to obtain necessary information to provide a preauthorization for a~~
10 ~~treatment, procedure, drug, or device];~~

11 4. Explanation that the failure of an insurer, limited health service
12 benefit plan, or private review agent to make a timely determination within the required time
13 frames shall be an adverse determination for the purpose of initiating an internal appeal;

14 5. The right to file a written complaint relating to utilization review
15 with the department in accordance with KRS 304.17A-613(8);

16 6. Except for an enrollee of a limited health service benefit plan:

17 a. Appeal rights to challenge an adverse determination,
18 including:

19 (i) Internal appeals, including expedited appeals; and

20 (ii) External reviews, including expedited reviews;

21 b. The right of a covered person to request departmental
22 review of a coverage denial after an insurer or private review agent upholds a coverage denial on
23 internal appeal, in accordance with KRS 304.17A-617(2)(e)4; and

1 c. The option of a covered person to request that an internal
2 appeal be conducted by a board eligible or certified physician in the appropriate specialty or
3 subspecialty area in accordance with KRS 304.17A-617(2)(c);

4 7. The right of a provider to review and comment on protocols
5 pursuant to KRS 304.17A-607(1)(k);

6 8. The right of a covered person to submit new clinical information at
7 any time during an internal appeal of an adverse determination or coverage denial to an:

8 a. Insurer; and

9 b. Provider; and

10 9. Except for an enrollee of a limited health service benefit plan, the
11 right of a covered person to submit new clinical information at any time during an external
12 review of an adverse determination or coverage denial to an:

13 a. Insurer;

14 b. Provider; and

15 c. Independent review entity; and

16 (m) If the applicant is a private review agent only, a listing of the entities for
17 which the private review agent is performing utilization review in this state in accordance with
18 KRS 304.17A-607(4).

19 (2) Upon receipt of an application for issuance or renewal of registration, the
20 department shall:

21 (a) Inform the applicant if supplemental information is or is not needed:

22 1. Applicant shall submit requested information within thirty (30)
23 days; or

2. If requested information is not provided to the department within thirty (30) days, the department shall:

a. Deny the application for issuance or renewal of registration; and

b. Not refund the application fee;

(b) Review the application and material required by KRS 304.17A-600 through 304.17A-619 and 304.17A-623, and Sections 2 through 11 of this administrative regulation; and

(c) Approve or deny issuance or renewal of registration.

(3) In order to be registered to perform utilization review in Kentucky, an applicant which holds accreditation or certification in utilization review by a nationally-recognized accreditation organization in accordance with KRS 304.17A-613(10) shall be required to submit with its completed application to the department:

(a) Evidence of current accreditation or certification in utilization review, which includes an expiration date; and

(b) Documentation to demonstrate compliance with requirements in accordance with KRS 304.17A-613(10).

Section 5. Denial or Revocation Hearing Procedure. Upon the denial of an application for issuance or renewal of a registration, or suspension or revocation of an existing registration, the department shall give written notice of its action and advise the applicant or registration holder that a request for a hearing may be filed in accordance with KRS 304.2-310.

Section 6. Utilization Review Complaint Process.

1 (1) A written complaint regarding utilization review shall be reviewed by the
2 department in accordance with KRS 304.17A-613(8):

3 (a) A written complaint may be:

- 4 1. Handwritten or typed;
- 5 2. Electronic; or
- 6 3. Transmitted by facsimile.

7 (b) A written complaint shall include any information relating to the
8 complaint.

9 (2) A copy of the complaint and a letter from the department shall be sent to the
10 insurer, including an insurer offering a limited health service benefit plan, or private review
11 agent in accordance with KRS 304.17A-613(8), requiring the following:

12 (a) Any information relating to the complaint; and

13 (b) A response by the insurer, including an insurer offering a limited health
14 service benefit plan, or private review agent to the complaint, including corrective actions to
15 resolve the complaint, if any, including time frames for those actions.

16 (3) Within thirty (30) days of completion of its corrective action, an insurer or private
17 review agent shall notify the department of the implementation of the corrective action.

18 (4) The number, severity, recurrence, and type of complaints, if any, shall be
19 considered by the department in reviewing an application for issuance or renewal of registration,
20 as required by KRS 304.17A-613(9).

21 Section 7. Internal Appeals for a Health Benefit Plan. In addition to the requirements of
22 KRS 304.17A-617, as part of an internal appeals process, an insurer or private review agent
23 shall:

(1) Allow a covered person, authorized person, or provider acting on behalf of a covered person, to request an internal appeal within a time frame of at least sixty (60) days after receipt of a denial letter;

(2) Provide written notification of a decision as required by KRS 304.17A-617(2)(a), which shall include the:

(a) Title, and if applicable, the license number, state of licensure and specialty certifications, if any, of the person performing the review;

(b) Elements required in a letter of denial in accordance with 806 KAR 17:230;

(c) Position and telephone number of a contact person who may provide information relating to internal review; and

(d) Date the decision was rendered;

(3) Maintain written records of all internal appeals received, including the:

(a) Reason for the internal appeal;

(b) Date of request that the internal appeal was received by the insurer or private review agent;

(c) Date of the internal appeal decision;

(d) Internal appeal decision; and

(e) Information required by Section 4(1)(j)5 of this administrative regulation;

and

(4) Retain a record of an internal appeal decision for five (5) subsequent years in accordance with 806 KAR 2:070.

Section 8. Internal Appeals for a Limited Health Service Benefit Plan.

(1) An insurer offering a limited health service benefit plan shall have an internal appeals process which shall:

(a) Be disclosed to an enrollee in accordance with KRS 304.17C-030(2)(g); and

(b) Include provisions which:

1. Allow an enrollee, authorized person, or provider acting on behalf of the enrollee to request an internal appeal within a time frame of at least sixty (60) days after receipt of a notice of adverse determination or coverage denial; and

2. Require the limited health service benefit plan to make a decision and provide a written internal appeal determination within thirty (30) days after receipt of a request for an internal appeal.

(2) A notice of adverse determination or coverage denial shall include a disclosure of the availability of the internal appeals process.

(3) The internal appeals process may be initiated by the enrollee, an authorized person, or a provider acting on behalf of the enrollee.

Section 9. Reporting Requirements. By March 31 of each calendar year, an insurer or private review agent shall submit to the department a HIPMC-UR-2 (07/04)[(11/02)]) for the previous calendar year.

Section 10. Maintenance of Records. An insurer or private review agent shall maintain:

(1) Adequate documents in order to assure compliance with KRS 304.17A-600 through 304.17A-619, 304.18-045, 304.32-147, 304.32-330, 304.38-225, and 304.47-050. Documentation shall include:

1 (a) Proof of the volume of reviews conducted per the number of review staff
2 broken down by staff answering the phone;

3 (b) Availability of physician consultation; and

4 (c) Other information which shall provide proof that based on call volume, the
5 insurers' private review agent has sufficient staff to return calls in a timely manner;

6 (2) Documentation in order to assure compliance with KRS 304.17A-600 through
7 304.17A-619, 304.18-045, 304.32-147, 304.32-330, 304.38-225 and 304.47-050. Documentation
8 shall include:

9 (a) Proof of the volume of phone calls received on the toll-free phone number
10 per the number of phone lines; and

11 (b) An abandonment rate; and

12 (3) Documentation to assure compliance with KRS 304.17A-600 through 304.17A-
13 619, 304.18-045, 304.32-147, 304.32-330, 304.38-225 and 304.47-050. Documentation shall
14 include proof of the insurer or private review agent's response time for returned phone calls to a
15 provider when a message is taken.

16 Section 11. Cessation of Operations to Perform Utilization Review.

17 (1) Upon a decision to cease utilization review operations in Kentucky, an insurer or
18 private review agent shall submit the following to the department thirty (30) days or as soon as
19 practicable [~~ninety (90) days~~] prior to ceasing operations:

20 (a) Written notification of the cessation of operations, including the proposed
21 date of cessation and the number of pending utilization review decisions with projected
22 completion dates; and

1 (b) A written action plan for cessation of operations, which shall be subject to
2 approval by the department prior to implementation.

3 (2) Annual reports required pursuant to Section 9 of this administrative regulation
4 shall be submitted to the department within thirty (30) calendar days of [~~prior to~~] ceasing
5 operations.

6 Section 12. Incorporation by Reference.

7 (1) The following material is incorporated by reference:

8 (a) "Utilization Review Registration Application, HIPMC-UR-1 (07/04)
9 [~~(10/02)~~]" ; and

10 (b) "Annual Utilization Review Report Form, HIPMC-UR-2 (07/04)
11 [~~(11/02)~~]" .

12 (2) This material may be inspected, copied, or obtained, subject to applicable
13 copyright law, at the Kentucky Office [~~Department~~] of Insurance, 215 West Main Street,
14 Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. Forms may also be
15 obtained on the department's web site at: <http://doi.ppr.ky.gov/kentucky/> [~~www.doi.state.ky.us~~].

READ AND APPROVED:

Glenn Jennings, Acting Executive Director
Kentucky Office of Insurance

Date

James Adams, Commissioner
Department of Public Protection

Date

LaJuana S. Wilcher, Secretary
Environmental and Public Protection Cabinet

Date

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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation 806 KAR 17:280E, Registration, utilization review, and internal appeal

Contact Person: Melea Kelch

(1) Provide a brief summary of:

- (a) What this administrative regulation does: This administrative regulation establishes a process and requirements for the registration of insurers or private review agents, and the utilization review process, including internal appeal of decisions. This regulation amends the existing regulation as needed and based on statutory creations and amendments during the 2004 session.
- (b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with 2004 Ky. Acts ch. 59 sec.5, KRS 304.17A-609, and KRS 304.17A-613 which require the Commissioner to promulgate emergency administrative regulations regarding utilization review, internal appeal, a process for the registration of insurers or private review agents and includes limited health service benefit plans and national accreditation organizations in the registration, utilization review, and internal appeal processes.
- (c) How does this administrative regulation conform to the content of the authorizing statutes: KRS 304.2-110 provides that the Commissioner of Insurance may make reasonable rules and administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.17A-609 and KRS 304.17A-613 require the Commissioner to promulgate emergency administrative regulations regarding utilization review, internal appeal, a process

- for the registration of insurers or private review agents. This regulation is intended to do that by making necessary amendments to this administrative regulation to conform with 2004 Ky. Acts ch. 59 sec. 5.
- (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist by providing the utilization review, internal appeal and registration process as required by KRS 304.17A-609, 304.17A-613, and 2004 Ky. Acts ch. 59 sec.5.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
- (a) How the amendment will change this existing administrative regulation? This administrative regulation changes the existing regulation to conform with 2004 Ky. Acts ch. 59 sec. 5.
- (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to comply with 2004 Ky. Acts ch. 59 sec. 5.
- (c) How the amendment conforms to the content of the authorizing statutes: The amendment is limited to including changes from the 2004 legislative session, specifically 2004 Ky. Acts ch. 59 sec. 5.
- (d) How the amendment will assist in the effective administration of the statutes: The Amendment will alter the regulation to comply with the amended statutes.
- (3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This regulation will effect consumers, insurers offering health benefit plans and offering limited health benefit plans in Kentucky.

- (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: This is an amendment to an existing administrative regulation and is required to conform the administrative regulation to the changes in statute during the 2004 session.
- (5) Provide an estimate of how much it will cost to implement this regulation:
- (a) Initially: The cost will be minimal
 - (b) On a continuing basis. There should be no additional cost on a continuing basis.
- (6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation? The budget of the Kentucky Office of Insurance.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. There will be no increase in fees or funding necessary to implement this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees or directly or indirectly increase any fees.
- (9) TIERING: Is tiering applied? Tiering is not applied because this regulation applies equally to all health insurers offering health benefit plans or limited health service benefit plans in Kentucky.

DETAILED SUMMARY OF INCORPORATED MATERIAL

806 KAR 17:280E

Registration, Utilization Review and Internal Appeal

(1) 806 KAR 17:280E incorporates by reference the following material that specifies the application instructions and reporting requirements of health insurers and private review agents:

(a) HIPMC-UR-1 (07/04)~~[(10/02)]~~, "Utilization Review Registration Application". The Utilization Review Registration Application provides instructions and forms that shall be used by all health insurers and private review agents making application for registration or changes in application to conduct utilization review in Kentucky. This form was changed to clarify the requirements under the statute and regulation.

(b) HIPMC-UR-2 (07/04)~~[(11/02)]~~, "Annual Utilization Review Report Form" is the form to be completed and filed annually with the department by health insurers or private review agents concerning utilization reviews conducted in the previous calendar year. This form was changed to bring the reporting requirements in line with statutory changes. Specifically, the changes were with the decision time frame as amended in Ky. Acts ch. 59, sec. 5.

(2) The total number of pages that the Office of Insurance has incorporated by reference is nine (9).